LakeView Family Dental

09141

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ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires us (in addition to our attempt to obtain our written acknowledgement, discussed above) to first obtain your written consent prior to disclosing any of your information except for our disclosure in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

✘ _____ ✘ _____

Patient Signature Patient Name (Please Print)

✘ _____

Date

Patient Consent

Please sign this form below under the heading "consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I consent to your disclosures of my information, which you deem are necessary information to carry out treatment, payment activities, and healthcare operations.

✘ _____ ✘ _____

Patient Signature Patient Name (Please Print)

✘ _____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ _____

_____

☐ An emergency situation prevented us from obtaining acknowledgement

Office Personnel: _____ Date: _____